FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027979

Facility Name: MONMOUTH NURSING HOME

Address: 116 SOUTH H (Number) MONMOUTH (City) 61462 (Zip Code)

County: WARREN

Telephone Number: 309-734-3811 **Fax #** ( )

IDPA ID Number: 0027979

Date of Initial License for Current Owners: 11-11-83

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: YVONNE CHUA **Telephone Number:** 636-394-3000

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10-1-99 to 9-30-00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) JAMES J. GIARDINA

(Title) PRESIDENT

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) DARRYL E. BUEKER, CPA

(Firm Name & Address) BAIRD, KURTZ & DOBSON, CPAS
PO BOX 1190, SPRINGFIELD, MO 65801

(Telephone) 417-865-8701 Fax # 417-865-0682

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,764	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	54	TOTALS	54	19,764	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	6,126	12,242		18,368	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,126	12,242		18,368	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.94%

D. How many bed-hold days during this year were paid by Public Aid?
42 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11-11-83

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11-11-83 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9-30-00 Fiscal Year: 9-30-00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	103,559	8,012	4,155	115,726		115,726		115,726			1
2	Food Purchase		75,353		75,353		75,353	(864)	74,489			2
3	Housekeeping	46,690	9,573		56,263		56,263	62	56,325			3
4	Laundry	37,184	5,570		42,754		42,754		42,754			4
5	Heat and Other Utilities			38,832	38,832		38,832		38,832			5
6	Maintenance	16,459	9,471	19,634	45,564		45,564	420	45,984			6
7	Other (specify):*											7
8	**TOTAL General Services**	203,892	107,979	62,621	374,492		374,492	(382)	374,110			8
	B. Health Care and Programs											
9	Medical Director			5,850	5,850		5,850		5,850			9
10	Nursing and Medical Records	424,834	23,438	65,731	514,003	(1,296)	512,707		512,707			10
10a	Therapy		133		133		133		133			10a
11	Activities	18,228	4,438	2,000	24,666		24,666	2	24,668			11
12	Social Services	19,356	14	2,940	22,310		22,310		22,310			12
13	Nurse Aide Training			2,917	2,917		2,917		2,917			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	462,418	28,023	79,438	569,879	(1,296)	568,583	2	568,585			16
	C. General Administration											
17	Administrative	40,625		216	40,841		40,841	18,410	59,251			17
18	Directors Fees											18
19	Professional Services			115,595	115,595		115,595	(106,737)	8,858			19
20	Dues, Fees, Subscriptions & Promotions			9,339	9,339		9,339	(3,659)	5,680			20
21	Clerical & General Office Expenses	5,927	2,037	15,236	23,200		23,200	35,583	58,783			21
22	Employee Benefits & Payroll Taxes			104,667	104,667		104,667	5,556	110,223			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,301	11,301		11,301	1,991	13,292			24
25	Other Admin. Staff Transportation							30	30			25
26	Insurance-Prop.Liab.Malpractice			6,095	6,095		6,095	310	6,405			26
27	Other (specify):*											27
28	**TOTAL General Administration**	46,552	2,037	262,449	311,038		311,038	(48,516)	262,522			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	712,862	138,039	404,508	1,255,409	(1,296)	1,254,113	(48,896)	1,205,217			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MONMOUTH NURSING HOME #0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			9,928	9,928		9,928	41,354	51,282			30
31	Amortization of Pre-Op. & Org.							168	168			31
32	Interest			765	765		765	85,353	86,118			32
33	Real Estate Taxes			35,495	35,495		35,495		35,495			33
34	Rent-Facility & Grounds			194,400	194,400		194,400	(187,480)	6,920			34
35	Rent-Equipment & Vehicles			805	805		805	1,707	2,512			35
36	Other (specify):*											36
37	**TOTAL Ownership**			241,393	241,393		241,393	(58,898)	182,495			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,646	29,646		29,646		29,646			42
43	Other (specify):* RX					1,296	1,296		1,296			43
44	**TOTAL Special Cost Centers**			29,646	29,646	1,296	30,942		30,942			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	712,862	138,039	675,547	1,526,448		1,526,448	(107,794)	1,418,654			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(864)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(479)	21		18
19	Entertainment	(583)	24		19
20	Contributions	(216)	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,533)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(178)	20		28
29	Other-Attach Schedule MISCELLANEOUS INCOME	(50)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (5,903)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(101,891)	VAR.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (101,891)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (107,794)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs	X		1,296	10.2	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,296		47

STATE OF ILLINOIS

MONMOUTH NURSING HOME

ID# 0027979

Report Period Beginning: 10-1-99

Ending: 9-30-00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISCELLANEOUS INCOME	$ (50)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
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57				57
58				58
59				59
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61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(50)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 **Report Period Beginning:** 10-1-99 **Ending:** 9-30-00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(864)	0	0	0	0	0	0	0	0	0	0	(864)	2
3	Housekeeping	0	62	0	0	0	0	0	0	0	0	0	62	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	420	0	0	0	0	0	0	0	0	0	420	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(864)	482	0	0	0	0	0	0	0	0	0	(382)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2	0	0	0	0	0	0	0	0	0	2	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	2	0	0	0	0	0	0	0	0	0	2	16
	C. General Administration													
17	Administrative	(216)	18,626	0	0	0	0	0	0	0	0	0	18,410	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(106,737)	0	0	0	0	0	0	0	0	0	(106,737)	19
20	Fees, Subscriptions & Promotions	(3,711)	52	0	0	0	0	0	0	0	0	0	(3,659)	20
21	Clerical & General Office Expenses	(529)	36,112	0	0	0	0	0	0	0	0	0	35,583	21
22	Employee Benefits & Payroll Taxes	0	5,556	0	0	0	0	0	0	0	0	0	5,556	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(583)	2,574	0	0	0	0	0	0	0	0	0	1,991	24
25	Other Admin. Staff Transportation	0	30	0	0	0	0	0	0	0	0	0	30	25
26	Insurance-Prop.Liab.Malpractice	0	310	0	0	0	0	0	0	0	0	0	310	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,039)	(43,477)	0	0	0	0	0	0	0	0	0	(48,516)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,903)	(42,993)	0	0	0	0	0	0	0	0	0	(48,896)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **MONMOUTH NURSING HOME** **# 0027979** **Report Period Beginning:** **10-1-99** **Ending:** **9-30-00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	41,354	0	0	0	0	0	0	0	0	0	41,354	30
31	Amortization of Pre-Op. & Org.	0	168	0	0	0	0	0	0	0	0	0	168	31
32	Interest	0	85,353	0	0	0	0	0	0	0	0	0	85,353	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(187,480)	0	0	0	0	0	0	0	0	0	(187,480)	34
35	Rent-Equipment & Vehicles	0	1,707	0	0	0	0	0	0	0	0	0	1,707	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(58,898)	0	0	0	0	0	0	0	0	0	(58,898)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(5,903)	(101,891)	0	0	0	0	0	0	0	0	0	(107,794)	45

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMES J. GIARDINA	100	MAR-KA NURSING HOME	MASCOUTAH	COMMUNITY	BALLWIN, MO	HOME OFFICE
		WEST MAIN NURSING HOME	MASCOUTAH	CARE CENTERS,	BALLWIN, MO	HOME OFFICE
				INC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	HOME OFFICE/MGMT FEES	$ 108,000	COMMUNITY CARE CENTERS, INC	COMMON	$ 73,634	$ (34,366)	1
2	V	34	BUILDING RENT	194,400	JAMES J. GIARDINA	100.00%		(194,400)	2
3	V	30	DEPRECIATION		JAMES J. GIARDINA	100.00%	41,354	41,354	3
4	V	32	INTEREST		JAMES J. GIARDINA	100.00%	85,353	85,353	4
5	V	31	AMORTIZATION		JAMES J. GIARDINA	100.00%	168	168	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 302,400			$ 200,509	$ * (101,891)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JAMES J. GIARDINA	PRESIDENT	GEN. DIRECTOR	100.00	0	4	5.71	SALARIES	$ 16,134	17.7	1
2	DOROTHY GIARDINA	VICE PRES/SEC		0.00	0	1	2.50	SALARIES	2,492	17.7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 18,626		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: COMMUNITY CARE CENTERS, INC
Street Address: 312 SOLLEY DRIVE - REAR
City / State / Zip Code: BALLWIN, MO 63021
Phone Number: (636-394-3000
Fax Number: (636-394-7713

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	HOME OFFICE	DIRECT COST			$	$		$	1
2		WEST COUNTY CARE CENTER						4,058,105	210,661	2
3		ST GENEVIEVE CARE CTR						1,815,682	94,255	3
4		CCC OF LEMAY						1,861,179	96,615	4
5		SALEM CARE CENTER						1,503,096	78,028	5
6		MONMOUTH NH						1,418,448	73,634	6
7		MAR-KA NH						1,981,823	102,878	7
8		WEST MAIN NH						906,323	47,049	8
9		CCC OF SENECA						2,243,581	116,468	9
10		MT VERNON PLACE CARE						2,126,851	110,409	10
11		COUNTRY VIEW NH						1,841,678	95,604	11
12		MERAMEC NH						1,743,248	90,493	12
13		SEVILLE CARE CENTER						1,969,138	102,221	13
14		SALEM RES. CARE						416,466	21,619	14
15		BOSS RES. CARE						110,788	5,750	15
16		CARL JUNCTION RES. CARE						514,891	26,729	16
17		MT VERNON RES. CARE						304,963	15,831	17
18		SENECA HOME PLACE						391,561	20,327	18
19		HUDSON HOUSE						389,647	20,227	19
20		MAPLE GROVE LODGE						1,984,236	103,005	20
21		SMITH BARR MANOR						1,333,076	69,202	21
22		CCC OF AURORA						3,339,388	173,351	22
23		BARRY COMMUNITY CARE						1,011,857	52,526	23
24		COMMUNITY IN HOME						290,180	15,064	24
25	TOTALS					$	$		$ 1,741,946	25

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	COLONIAL PACIFIC LEASING		X	COMPUTER SOFTWARE	$349.00	6/97	$ 9,915	$	6/00	15.0000	$ 765	1
2	CAPITAL LEASE											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$349.00		$ 9,915	$			$ 765	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,915	$			$ 765	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 **Report Period Beginning:** 10-1-99 **Ending:** 9-30-00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	24,540	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	34,295	2
3. Under or (over) accrual (line 2 minus line 1).	$	9,755	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	25,740	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	35,495	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	32,997	8
	1996	34,212	9
	1997	35,124	10
	1998	32,245	11
	1999	34,295	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,000 B. General Construction Type: Exterior BRICK VENEER Frame FRAME Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		50,094	1983	$ 12,180	1
2			1990	7,500	2
3	TOTALS	50,094		$ 19,680	3

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	35		1983	1959	$ 424,640	$	10-20	$ 21,250	$ 21,250	$ 367,220	4
5	19			1990	653,401		3-30	20,104	20,104	244,623	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	DRAPERY AND CUBICAL			1991	4,570	457	10	457		4,378	10
11											11
12	ROOF REPAIRS			1992	3,181	318	10	318		2,743	12
13											13
14	CARPETING			1992	4,074		5			4,074	14
15											15
16	CARPETING			1993	4,411		5			4,411	16
17											17
18	VANGUARD SYSTEM			1996	630	309	15	309		1,545	18
19											19
20	ROOF REPAIRS			1996	1,380	138	10	138		621	20
21											21
22	ALARM			1997	7,078	472	15	472		1,416	22
23											23
24	WATER HEATER			1998	3,275	327	10	327		886	24
25											25
26	NURSE CALL SYSTEM			2000	7,347	306	10	306		306	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,113,987	$ 2,327		$ 43,681	$ 41,354	$ 632,223	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 73,000	$ 6,708	$ 6,708	$	5-25	$ 40,699	37
38	Current Year Purchases	15,965	893	893		10-12	893	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 88,965	$ 7,601	$ 7,601	$		$ 41,592	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,222,632	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 9,928	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 51,282	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 41,354	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 673,815	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: RELATED PARTY LEASE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 805 Description: PAGERS
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$ 425	$ 1,843	$	$ 2,268
2	Books and Supplies		67	432		499
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			150		150
9	TOTALS		$ 492	$ 2,425	$	$ 2,917
10	SUM OF line 9, col. 1 and 2	(e)	$ 2,917			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9-30-00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 34,117	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 8,000)	79,845		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,148		6
7	Other Prepaid Expenses	220		7
8	Accounts Receivable (owners or related parties)	86,411		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 206,741	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	39,946		15
16	Equipment, at Historical Cost	88,965		16
17	Accumulated Depreciation (book methods)	(61,971)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS/INC. TAXES	2,235		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 69,175	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 275,916	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 39,253	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,609		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,678		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,740		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTIES	5,000		36
37	PATIENT FUNDS	279		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 120,559	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 120,559	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 155,357	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 275,916	$	48

***(See instructions.)**

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 134,526	1
2	Restatements (describe):		2
3	PRIOR PERIOD INCOME TAXES	(9,941)	3
4	PRIOR PERIOD ROUNDING	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 124,587	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	30,770	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 30,770	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 155,357	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,647,520	1
2	Discounts and Allowances for all Levels	(115,099)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,532,421	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,216	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	23,500	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 24,716	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	50	28
28a	TRADE DISCOUNTS	31	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 81	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,557,218	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	374,492	31
32	Health Care	569,879	32
33	General Administration	311,038	33
	B. Capital Expense		
34	Ownership	241,393	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	29,646	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,526,448	40
41	**Income before Income Taxes (line 30 minus line 40)****	30,770	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 30,770	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** **TAX RETURN ON CASH BASIS**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,855	1,855	$ 31,971	$ 17.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,297	2,335	34,845	14.92	3
4	Licensed Practical Nurses	9,136	9,914	114,042	11.50	4
5	Nurse Aides & Orderlies	31,931	33,269	243,976	7.33	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,125	2,241	18,228	8.13	9
10	Activity Assistants					10
11	Social Service Workers	1,974	2,186	19,356	8.85	11
12	Dietician					12
13	Food Service Supervisor	2,115	2,247	18,563	8.26	13
14	Head Cook	5,569	5,951	38,535	6.48	14
15	Cook Helpers/Assistants	7,385	7,599	46,461	6.11	15
16	Dishwashers					16
17	Maintenance Workers	2,076	2,220	16,459	7.41	17
18	Housekeepers	7,848	8,250	46,690	5.66	18
19	Laundry	6,432	6,518	37,184	5.70	19
20	Administrator	2,080	2,080	40,625	19.53	20
21	Assistant Administrator					21
22	Other Administrative	833	847	5,927	7.00	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	83,656	87,512	$ 712,862 *	$ 8.15	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	130	$ 4,155	1.3	35
36	Medical Director	52	5,850	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	97	1,200	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	44	2,940	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	323	$ 14,145		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	78	$ 3,405	10.3	50
51	Licensed Practical Nurses	329	9,125	10.3	51
52	Nurse Aides	2,408	52,001	10.3	52
53	TOTAL (lines 50 - 52)	2,815	$ 64,531		53

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CINDY ZOLPER	ADMINISTRATOR		$ 40,625
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 40,625

B. Administrative - Other

Description	Amount
DONATIONS	$ 216
TOTAL (agree to Schedule V, line 17, col. 3)	$ 216
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
COMMUNITY CARE		$
CENTERS, INC	MGMT FEES	108,000
BAIRD, KURTZ &		
DOBSON	ACCOUNTING	7,595
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 115,595

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,131
Unemployment Compensation Insurance	
FICA Taxes	64,320
Employee Health Insurance	10,304
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	3,912
HOME OFFICE ALLOCATION	5,556
TOTAL (agree to Schedule V, line 22, col.8)	$ 110,223

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,968
Health Care Worker Background Check	
(Indicate # of checks performed 33)	398
ADVERTISING OTHER	3,711
TAXES AND LICENSES	515
DUES AND SUBSCRIPTIONS	2,747
HOME OFFICE ALLOCATION	52
Less: Public Relations Expense	( )
Non-allowable advertising	(3,533)
Yellow page advertising	(178)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,680

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,370
MEALS	583
Seminar Expense	2,348
HOME OFFICE ALLOCATION	2,574
Entertainment Expense	(583)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,292

**See instructions.

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10-1-99 Ending: 9-30-00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC. $2,227**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **29,646**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation. TRAVEL TO/FROM HOME OFFICE (STL, MO)
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **54%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **BAIRD, KURTZ & DOBSON** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **TO BE SENT WHEN COMPLETED**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **N/A**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.